STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON & HATTIE KUTZ HOME	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 30, 2012 through February 10, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 84. The Stage 2 survey sample totaled fifty-one (51) residents.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	**F 164**	1. The worksheet was removed and the facility toured to ensure no confidential resident information was in public areas. 2. A. The facility has a "HIPPA/Confidentiality" Policy as part of the Employee Handbook, which is reviewed at orientation and annually (see attached). A new "Resident confidentiality/HIPPA" policy specific for the nursing department was developed (see attached) B. An in-service regarding confidentiality of resident information was completed for nursing staff (see attached) 3. The Supervisor report sheet, completed each shift has been updated to include monitoring to insure that confidential resident information is not left in public areas. (see attached form) 4. Supervisor reports will be reviewed by the DON or designee and reviewed at the monthly QA meeting.	3/7/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

EXECUTIVE DIRECTOR 3/8/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the privacy of medical information from the residents' medical records for 20 (R65, R111, R83, R63, R27, R106, R99, R66, R92, R84, R31, R37, R72, R53, R88, R87, R33, R52, R50, R86) out of 51 Stage 2 sampled residents. Findings include: Review on 2/8/12 of the facilities Admission Packet revealed that, per facility policy, it states "Each resident shall have the right of privacy over his/her own clinical, health, and medical records...personal and medical records shall be treated confidentially, and shall not be made public without the consent of the resident, except as such records are needed in the event of transfer to another health care institution or as required by law or third party payment contract". On 2/8/12, a family member who wished to remain anonymous, gave the surveyor a Certified Nursing Assistant (C.N.A.) Data Sheet that he found lying open on the table with residents' names showing. The paper had the names of R65, R111, R83, R63, R27, R106, R99, R66, R92, R84, R31, R37, R72, R53, R88, R87, R33, R52, R50, R86 along with the personal information for each resident which included whether they were continent /incontinent, what their diet was, bath day schedule, how they were transferred and if they had any adaptive equipment such as wheelchair or walker and	F 164		

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F 164	Continued From page 2 alarms. This list also included categories for pain and behaviors. The facility failed to ensure privacy of 20 residents medical information on the CNA data sheet. On 2/8/12, in an interview with E8 (Activity Director), she confirmed that she saw the paper with the resident's name and personal information on it lying on the table, and that she thought it was a CNA schedule. She stated that she folded up the paper and put it on top of the piano in the activity room.	F 164		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that six (R22, R26, R27, R45, R55 and R82) out of 51 Stage 2 sampled residents had reasonable accommodations of their needs. The facility failed to ensure that these resident's call bells were within reach. Findings include: Review of the facility policy entitled, "Call Lights/Call Bells" which was revised on 7/2010 revealed, "It is the policy of this facility to respond promptly to a resident's call for assistance".	**F 246**	1. Unable to make corrections on this past practice. 2. A. The "Call light/Call bell" policy was revised to include disinfecting a call bell when picked up off the floor. (see attached) B. An in-service regarding proper call bell placement was provided for nursing staff (see attached) 3. The daily Supervisor report sheet, completed each shift has been updated to include monitoring for proper call bell placement. (see attached form) 4. Supervisor reports will be reviewed by the DON or designee and reviewed at the monthly QA meeting.	**3/7/12**

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F 246	Continued From page 3 Procedure # 6 stated, "Place the call light within the resident's reach at all times". 1. An observation on 2/6/12 at 10:43 AM, during the environmental tour with E19 (Maintenance Director), revealed that R22's call bell was not within reach. R22 was observed lying on the bed and the call bell was on the floor on the right side of the bed. E17 (nurse) was observed picking up the call bell and placing it within R22's reach. E17 confirmed that the call bell should have had been within reach and that R22 could not get the call bell in the position he was in. On 2/7/12, in an interview with E3 (Assistant Director of Nursing) and E16 (RN Staff Development), the surveyor reviewed the findings regarding the call bells not being within reach. 2. An observation made on 2/8/12 of R26's room revealed that R26's call bell was inaccessible to the resident. R26 was observed sitting in his room in his wheelchair between the bathroom and the footboard of his bed. R26's call bell was observed at the far end of the headboard of his bed. In an interview on 2/8/12 with E4 (Nurse), she confirmed that the call bell was not within reach and stated that the resident needed assistance to move within his room. 3. An observation on 1/31/12 revealed that R27's call bell was inaccessible to the resident. R27 was observed sitting in her wheelchair next to the edge of the footboard of her bed and the call bell was on the bed by her headboard area. On 1/31/12, E20 confirmed the call bell was not	F 246		

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F 246	Continued From page 4 within reach and stated that R27 could not move herself in the wheelchair within the room. An observation on 2/1/12 revealed that R27's call bell was inaccessible to the resident. R27's call bell was observed wrapped on the right side of the bed support bar on the outside of the bed behind R27's head. R27 was unable to locate the call bell when she attempted to reach it. On 2/1/12, E9 (Nurse) confirmed the findings. 4. An observation on 2/1/12 revealed that R45's call bell was inaccessible to the resident. R45's call bell was observed tucked in on the side of the bed between the mattress and the enabler while the resident was laying on the bed. On 2/1/12, during an interview with R45, she stated she could not reach the call bell. She made a few unsuccessful attempts to reach the call bell. R45 stated that she couldn't move by herself in bed. R45 stated that the staff frequently placed the call bell where she couldn't reach it. On 2/1/12, E9 confirmed that the call bell was not within reach for R45. 5. An observation on 2/6/12 at 12:25 PM, during the environmental tour with E21 (Housekeeping), revealed that R55 was sitting in her room in her wheelchair and the call bell was inaccessible to the resident. In an interview on 2/6/12 with E22 (Nurse), she confirmed that the resident could not reach her call bell. Also, E22 stated that the resident could not move herself when in her wheelchair.	F 246		

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F 246	Continued From page 5 Findings were reviewed with E16 on 2/7/12 at 3:20 PM. 6. Observations were made on 2/3/12 at 8:05 AM, 2/7/12 at 8:35 AM and 2/9/12 at 7:40 AM that revealed R82's call bell was inaccessible. During each of these observations, R82 was observed sitting in her wheelchair in her room while the call bell was on the opposite side of the bed wrapped around the positioning bar. R82 stated that she could not reach the call bell. Additionally, there was a sign on the wall outside the bathroom that read, "Don't stand up alone. Push red button to call nurse." In an interview on 2/7/12 at 11:55 AM, E7 (Certified Nursing Assistant) stated, "Resident cannot walk or transfer by herself. Resident can use the call bell".	F 246		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: On 2/6/12, during the environmental tour with E19	F 253	1. No resident was affected by this action. 2. The sinks in rooms 601 and 606 have been repaired and now operate properly; additionally, all resident room sinks have been checked and operate properly 3. All Housekeeping and Maintenance staff have been educated to inform maintenance when a sink is not functioning properly. Education was centered on the proper use of the Work Order Program. (see attached) 4. Scheduled Preventative Maintenance will be performed on all resident room sinks on a monthly basis (see attached form). The Maintenance Director will monitor for compliance and report findings at the monthly QA meeting.	3/7/12

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F 253	Continued From page 6 (Maintenance) and E21 (Housekeeping) observations revealed that the hand sinks in rooms 101, 601 and 606 were plugged and would not drain properly. The sinks filled up when water was run and took several minutes to drain. On 2/6/12, during an interview with E19 and E21, these findings were confirmed. Observations on 2/9/12 of rooms 601 and 606 revealed that the hand sinks in these rooms continued to be plugged, not draining properly.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	1. Coding has been corrected on the MDS for residents R101 and R22. (see attached) 2. A. All residents were screened for accuracy of dental assessment and psychiatric diagnosis. (see attached forms) B. All MDS's have been reviewed for accurate dental assessment and psychiatric diagnosis coding 3. A. Using the MDS/Care Planning Audit Log the current MDS will be compared to the residents Care Plan to ensure accuracy of both documents. (see attached form). Each resident will be reviewed according to the Care Plan/MDS schedule. B. Interdisciplinary Team has been in-serviced on use of this Audit log (see attached) 4. Findings of the audits will reviewed at the monthly QA meeting.	3/7/12

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F 278	Continued From page 7 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to accurately assess the residents' status for two (R22 and R101) out of 51 Stage 2 sampled residents on Minimum Data Set (MDS) Assessments. For R101, the facility failed to include the diagnosis of Psychosis on the quarterly MDS, dated 1/16/12. For R22, the facility failed to correctly code broken natural teeth on the admission MDS, dated 12/28/11. Findings include: 1. Review of the nurses' notes (NN), dated 12/1/11 at 6:30 PM, revealed that R101 was very upset about a haircut during the shift and put lipstick in her hair. Review of a NN, dated 12/11/11, revealed that R101 called the police (911) at 2:30 PM and was using foul language. Review of the NN, dated 12/12/11, noted that R101 had nail polish on her face this morning. Review of the NN, dated 2/5/12, revealed that R101 was yelling, using foul and threatening language and knocked over the bedside table. R101 received the afternoon dose of the anti psychotic medication, Seroquel, and was smiling and calm by the end of the shift. During December 2011, R101 was admitted to a psychiatric hospital from the facility and returned to the facility on 12/20/11 with diagnosis of Major Depressive Disorder and recurrent, severe Psychosis (Psychosis is a loss of contact with	F 278		

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F 278	Continued From page 8 reality, usually including delusions and hallucinations). Review of the quarterly MDS, dated 1/16/12, revealed the facility failed to include Psychosis as an active diagnosis. On 2/8/12, in an interview with E13 (RNAC) she confirmed the findings. 2. R22 was admitted to the facility on 12/21/11 with diagnoses that included pressure ulcer of the hip, open wound wrist, muscular wasting, coronary artery disease, hypertension and cancer of the prostate and bladder. An observation of R22 on 02/01/12 at 08:40 AM, revealed that his left lower incisor was chipped/broken. R22 stated that it did not hurt him and that he brushed his own teeth. An observation of R22 on 2/3/12 at 12:10 PM, during lunch revealed R22 was eating comfortably and did not appear to have problems eating. R22's teeth were observed and he had missing bottom teeth on right and left toward the back and had a chipped tooth in front. The admission MDS, dated 12/28/11, failed to code under oral/dental status that R22 had broken natural teeth. On 2/3/12, in an interview E13 (RNAC) confirmed the findings.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 9 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to review and revise the care plan for one (R101) out of 51 Stage 2 sampled residents. Findings include: R101 was admitted to the facility on 10/18/11 and the fall evaluation done upon admission had a score of 15. On 1/16/12, the fall evaluation score equaled 12. A score of 10 or higher is considered "at risk". On 12/30/11, R101's physician wrote an order for the use of bed and chair alarms with R101. On 1/31/12, in an interview with E4 (nurse), she stated that R101 fell on 1/22/12 in the bathroom. On 2/3/12, E4 also stated that R101's alarm was sounding when she fell but that R101 was impulsive. E4 stated that the use of the call light	**F 280**	1. The care plan has been updated for resident R101 to include safety devices as ordered (see attached) 2. Audits were completed to ensure accuracy of all care plans. 3. A. Using the MDS/Care Planning Audit Log the current MDS will be compared to the residents Care Plan to ensure accuracy of both documents. (see attached form). Each resident will be reviewed according to the Care Plan/MDS schedule. B. Interdisciplinary Team has been in-serviced on use of this Audit tool (see attached) 4. Findings of the audits will reviewed at the monthly QA meeting.	**3/7/12**

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F 280	Continued From page 10 before getting out of the wheelchair was reinforced with the resident. R101 was sent out to the hospital and had steri strips applied to the right elbow and right shin. Observations were made of R101 with the use of an alarm on her wheelchair on 1/31/12 and 2/3/12. Also, a bed alarm was observed on R101's bed on 2/1/12. Review of the Treatment Records (TAR) and Certified Nursing Assistant (CNA) flow sheets for 1/12 and 2/12 through 2/7/12 revealed that there was documentation regarding the use of bed and chair alarms for R101. However, the Potential for Injury related to Fall Care Plan, developed on 10/20/11 and last revised on 1/25/12, failed to be revised to include the interventions of the bed and chair alarms. On 2/8/12, in an interview findings were confirmed by E13 (RN Assessment Coordinator) and E14 (LPN Medical Records).	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of	F 309		

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F 309	Continued From page 11 other documentation as indicated, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care for one (R109) out of 51 Stage 2 sampled residents. The facility failed to coordinate care with the dialysis center and failed to confer with the dialysis center regarding any updates or changes that may have required a change in medication and/or treatment for R109 and failed to have consistent monitoring of vital signs, access site assessments including checking for bruit and thrill of the resident's shunt per shift. Additionally, the facility failed to follow the physician's orders, dated 1/26/12, regarding obtaining weights three times per week and maintaining a 1200 cc fluid restriction. Findings include: Review of the facility policy, dated Rev (revised) 01/2012 and entitled, "Care of Dialysis Resident" stated, "Procedure: ...3. Physician orders will be obtained for specific fluid restrictions, weight monitoring, diet, labs, etc as requested by the physician or dialysis center staff. 4. Nursing staff will check for positive bruit, thrill and monitor for bleeding every shift..." R109 was admitted to the facility on 1/18/12 for rehab with diagnoses that included end stage renal disease (ESRD), right above the knee amputation, hypercalcemia, hypertension, C-Diff, shortness of breath and depression. Review of R109's physician admission/monthly order sheet, dated 1/18/12, stated that R109 was ordered dialysis services three times a week on Tuesday, Thursday and Saturday; a mechanical	**F 309**	1. An inter-facility Dialysis Communication form documenting resident status pre and post dialysis was initiated and implemented on 2/10/12. (see attached form) 2. Medical record of resident R109 and any future residents receiving dialysis will be audited weekly for compliance of obtaining weights and other care protocols during the weekly SWIFT (Skin, Weights, Infections, Falls, Therapy) team meetings using the Weekly Dialysis Audit Tool. (see attached form) 3. A. The "Care of a Dialysis Resident" and "Fluid Restriction" policies were revised to include physician review of the dialysis communication form. (see attached) B. All physicians were made aware of the policy revision and the dialysis communication form. (see attached letter) C. Nursing staff have been in-serviced on the policy revision and the dialysis communication form. (see attached) 4. Findings of the audits will reviewed at the monthly QA meeting.	**3/7/12**

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F 309	Continued From page 12 soft diet and Nepro 40 milliliters times 18 hours via a peg tube (feeding tube) to be started at 12 noon and taken down at 6 AM. This order was discontinued and another order, dated 2/18/12 stated, "Nepro 60cc hour from 6 PM to 6 AM, 25 cc auto flush hour, 250 cc H2O (water) TID (three times a day) flush per shift." Review of R109's "Daily Skilled Nurse's Notes", dated from 1/18/12 through 2/4/12, lacked evidence that the dialysis shunt was checked for bruit and thrill as per facility policy for 43 of 54 shifts. On 1/28/12 and 1/29/12, there was no evidence of vital signs being done on night shifts. On 1/24/12, there was no evidence on any type of nursing assessment or vitals signs done on the night shift. R109's physician's order, dated 1/26/12, stated, "D/C (discontinue) 250 cc flush TID (three times a day); 1200 cc Fluid Restriction; Wghts (weights) 3 X (times) weekly; Continue Tube Feed and Auto Flush; Give 4 oz (ounces) on 7-3, 4 oz on 3-11 and 4 oz 11-7 of fluid." Another physician order, dated 1/26/12, stated, "Clarification of Order: Give 4 oz of fluids q (every) shift." Review of R109's 1/12 MAR (Medication Administration Record) revealed an order, dated 1/18/12, for "Weekly wt x 4 wk (weeks) to be done on the 7-3 shift. Weights were recorded on 1/18/12, 1/23/12 and 1/30/12. The facility failed to transcribe the new order, dated 1/26/12, for obtaining weights three times a week onto the 1/12 MAR and failed to follow the physician's order to obtain them. Review of R109's 2/12 MAR revealed the order,	F 309		

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F 309	Continued From page 13 dated 1/18/12, for weekly weights X 4 weeks with 2/6/12 and 2/13/12 blocked to obtain the weights (#3 & #4) was still listed. However, the new order, dated 1/26/12, for obtaining weights three times weekly did not get added to the 2/12 POS (Physician Order Sheet) or the 2/12 MAR. Another physician's order, dated 2/3/12 and timed 0900 (9AM) stated, "Clarification order: Resident to be weighed 3 X a wk on Mon., Wed., Fri." This order was transcribed onto the 2/12 MAR and a weight was obtained on 2/3/12. However, there was no weight done on 2/1/12. During an interview on 2/9/12, E11 (nurse/unit manager) was asked how the facility coordinates care and communicates information with the dialysis services provider. E11 stated that she was unsure but thought communication was done by telephone. She stated that the resident is weighed three times a week by the facility and is also weighed by dialysis on dialysis days. When asked what nursing should be monitoring for a dialysis resident, she stated I & O's (intake and output), vitals signs and to monitor for signs and symptoms of bleeding. At 9:10 AM, on 2/9/11, E11 telephoned the nurse practitioner at the dialysis center and requested communication of weights and vital signs from dialysis, informed dialysis of new physician's order for 1000 cc fluid restriction and then, proceeded to ask what was the standard of practice for checking a bruit. After hanging up the telephone, E11 stated that the nurse practitioner at dialysis told her that the facility only needed to monitor for bleeding. E11 stated that she was not sure what the standard was in the facility... "used to know" what it was when she worked in the hospital.	F 309		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 14 During an interview on 2/9/11 at 2:30 PM, E4 (nurse) stated that R109 went to dialysis three times a week, and that as far as she knew the nurse practitioner from dialysis telephones and gives a verbal report to the 3-11 shift nurse upon the resident's return to the facility. E4 did not know what the policy was for dialysis patients and stated, "I would have to ask what the policy is for getting information from dialysis." E4 denied sending any written information, such as vital signs, weights, etc. with R109 when the resident went to dialysis. E4 denied personally communicating with dialysis in any manner, written or verbally, by phone or otherwise. E4 reviewed R109's I & O sheet with the surveyor. Review of R109's "Total Intake and Output Record" revealed zero output and intakes that exceeded the 1200 cc fluid restriction ranging from the highest intake of 2885 cc on 1/27/12 to the lowest exceeded intake of 1213 cc on 2/4/12. E4 acknowledged that the daily totals of R109's intake from 1/26/12 through 2/4/12 exceeded R109's ordered 1200 cc fluid restriction. Additionally, she stated R109's family was non compliant with the fluid restriction and was giving additional fluids to the resident above these totals. E4 stated that the resident does not void and therefore has no output. E4 stated that she knew that nursing was supposed to check R109's shunt for a positive bruit and thrill, signs and symptoms of bleeding, and do vital signs for each shift. E4 confirmed that review of R109's clinical record lacked evidence that this was always done. On 2/9/11 at 3:00 PM, E4 informed the surveyor that she had spoken with E2 (Director of Nursing)	F 309		

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F 309	Continued From page 15	F 309		

and was told that it is expected that dialysis would call and give report to the facility. E4 stated that R109 leaves for dialysis at 9:30 AM and again stated that she does not send any communication with the resident or call prior to resident going out to dialysis. E4 stated that she thought E25 (nurse on 3-11) would get report from dialysis... that was what she had been told.

During an interview on 2/9/12 at 3:20 PM, E25 stated that she had questioned E11, the unit manager, regarding the lack of fluid restriction orders upon R109's admission on 1/18/12. E25 stated that E11 called the physician and was told to call nephrology. E25 stated that when she returned to work a couple of days later, she obtained the order from the nurse practitioner at dialysis for a fluid restriction of 1200cc/24 hr period but that by then the resident had already gained weight. E25 stated that on 1/26/12, E11 called the physician regarding the fluid restriction and that the physician told her to talk to dietary. However, E11 left as it was the end of her shift. E26 (Registered Dietician) was contacted so she could calculate how the fluids should be divided between nursing and dietary. E25 denied receiving any copy or any other type of communication from the dialysis center and stated that the only communication in the clinical record was the lab results, dated 1/20/12, which E11 had requested. E25 denied having any other verbal or written communication with dialysis regarding R109 and stated that E2 "would probably implement something now."

E25 was knowledgeable regarding R109's condition. E25 stated that she monitored resident's shunt site for signs and symptoms of

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F 309	Continued From page 16 bleeding, checked bruit and thrill... at least once a shift. E25 acknowledged that while nursing was supposed to check R109's shunt for a positive bruit and thrill, signs and symptoms of bleeding, and do vital signs for each shift, review of R109's clinical record lacked evidence that this was always done. E25 stated that R109 had told her that she does not void. When questioned regarding R109's hospitalization on 2/5/12, E25 stated that the resident had dialysis services on 2/4/12 and had no shortness of breath on 3-11 shift but had complained of shortness of breath early on the morning of 2/5/12. She stated the resident was given a respiratory treatment with some relief but subsequently was sent out to the hospital for continued complaints of shortness of breath. Review of the clinical record revealed that the resident was readmitted to the facility on 2/8/12 with a diagnosis of "SOB (shortness of breath)/ fluid overload." When discussing R109's fluid restriction of 1200 cc/day, E25 stated that she would start the resident's tube feeding at 6 PM and had administered R109's oral medications with 60 cc of water to drink, and that R109 would have cranberry juice with her dinner which she calculated to be 240 cc. This was despite a physician's order, dated 2/2/12, that stated, "Clarification Nursing to give meds c (with) pudding or applesauce. Dietary to give 4 oz c breakfast, lunch and dinner." E25 reviewed R109's daily I & O sheets, dated 1/26/12 through 2/4/12 and acknowledged that each day, R109's intake exceeded the ordered 1200 cc fluid restriction. Findings were discussed with E2 during an interview on 2/9/12 at 3:35 PM. E2 stated that the physician ordered weights and fluid	F 309		

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F 309	Continued From page 17	F 309		

restrictions. She stated that staff should pass on in report to the next shift if a family or resident is non compliant with fluid restrictions, as well as the resident's I & O and fluid restriction. E2 stated that she would expect nursing to document in their nurse's notes and/or on the MARs the evidence of regular shunt care such as checking for bruit and thrill... and for it to be in the care plan. E2 stated, "It is my experience that there is usually not a report given to dialysis"... that a type of "report card" would be received from dialysis once a month. When questioned if any such report card had been received, she stated, "No, I don't believe we have." She stated that dialysis did the resident's lab work, administered medications, weighed resident pre and post dialysis and monitored the resident's shunt. E2 stated, "We (facility) could send them (dialysis) their (resident's) weight but, dialysis would probably do their own..." When asked how would coordination of care be done, she stated that "if we needed to tinker with her diet... ", it would be done at care plan meeting or through SWIFT (Skin, Weight, Infections, Falls, Treatments) meetings. E2 denied having any communication with the dialysis unit herself and could not say if any of the nursing staff did. She stated that this is the first dialysis patient that the facility has had since she started working in the facility in July 2011. E2 confirmed that R109's intake exceeded the 1200 cc fluid restriction everyday from 1/26/12 through 2/4/12.

On 2/10/12 at 7 AM, E3 (ADON) approached the surveyor upon entering building with a dialysis communication form that she stated the facility had just developed "after talking with the dialysis contractor last evening" on 2/9/12 after survey

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F 309	Continued From page 18 team had left the facility. E3 stated that the facility had just revised their policy on the care of dialysis resident to reflect this and provided a copy of the new policy, dated Rev: 02/2012 and entitled, "Care of Dialysis Resident" and the form, dated Rev: 02/2012 and entitled, "(Name of facility)/Dialysis Communication Form." Review of the new policy revealed that the procedure now included the following: "... The facility will utilize the... Communication form to communicate and collaborate resident care with the dialysis center. This form will be completed by the facility nurse and sent with the resident to the dialysis center. Once the resident returns from dialysis, the form will be reviewed for any changes as well as updates on the resident's condition." During an interview on 2/10/12, E11 acknowledged the findings and stated that weights were missed on 2/1/12 because the order was not carried over to the 1/12 MAR or 2/12 MAR. The facility failed to ensure follow the physician's order regarding the 1200cc fluid restrictions, failed to obtain all physician ordered weights, failed to consistently monitor and document R109's vital signs and assess her shunt as per the facility policy. Additionally, the facility failed to coordinate dialysis care with the dialysis treatment center and failed to communicate pertinent resident assessment information such as vital signs, weights, etc. until interviewed by the surveyor. The resident had been hospitalized for shortness of breath and readmitted to the facility with a diagnoses that included "fluid overload."	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 19 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that the resident's environment remained as free of accident hazards as is possible. The facility failed to ensure that medication carts were locked on the 100 and 200 units on 2/6/12. Additionally, the doors to the 300 unit nursing supply room and the 600 unit soiled utility room storing biohazard waste were observed unlocked. Findings include: Review of the Facility's policy and procedure, dated Rev (revised): 07/2010 and entitled, "Administering Medications" stated, "...14. During medication passes, the medication cart is never to be left unattended or unlocked." 1. On 2/6/12 at 9:20 AM, an observation was made of a medication cart unlocked and unattended in the 100 hallway. There was no nurse in the hallway. When the surveyor opened the medication cart drawers, E9 (nurse) came out of a room. On 2/6/12, upon E9's return to the medication cart, E9 stated that he left the med cart to go into	F 323	**F 323** **#1 and #2** 1. Unable to make correction on this past practice 2. Residents identified or no other residents were affected by this practice 3. A. Nursing staff was in-serviced on proper security of medication carts and the need to immediately report safety concerns or items in disrepair to Maintenance (see attached) B. The Supervisor report completed each shift has been revised to include monitoring of all medication carts to insure they are locked when nurse is not in attendance. (see attached form) C. Medication Pass Competencies were completed and include security of medication carts. (see attached form) D. DON or designee will review the Supervisor reports and respond to any concerns related to medication cart security.	

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F 323	Continued From page 20 a resident room and that he should have locked the med cart before leaving it. 2. During the medication pass observation on 2/6/12 at 9:10 AM, E12 (nurse) entered R20's room and proceeded to close the resident's door, stating that she needed to provide the resident privacy while applying a pain patch to her back. E12 was stopped by the surveyor and asked to check the med cart that remained outside R20's room in the hall, unlocked and out of E12's view. E12 confirmed that the medication cart was unlocked and immediately locked the cart. During the informational meeting on 2/10/12, findings were discussed and acknowledged by E1 (Administrator) and E2 (Director of Nursing). E1 stated that E12 had been removed from the schedule and would not be returning to the facility. 3. On 1/31/12 at 12:05 PM, the door to the 300 unit nursing supply room was observed unlocked although it was supposed to be locked. The keypad door lock mechanism was not working properly. On 1/31/12, in an interview with E4 (nurse), she confirmed the findings and notified maintenance. 4. On 2/9/12 at 1:25 PM, the door to the 600 unit soiled utility/ biohazard room was observed unlocked. The room stored biohazard waste and soiled linen. The surveyor unlocked the door by pulling on the door knob which opened the door at least four times despite having a keypad lock. The lock was not working properly.		**F 323** **#3 and #4** 1. No resident was effected by this practice 2. The lock on the nursing supply room was replaced on 2/8/12; the lock on the soiled utility room was repaired on 2/10/12 3. A. Scheduled Preventative Maintenance will be performed on all secured doors on a quarterly basis (see attached). The Maintenance Director will monitor for compliance. B. Maintenance, Housekeeping staff have been in-serviced on the need to immediately report safety concerns or items in disrepair to Maintenance 4. **For #1, #2, #3 &# 4** Findings of reports will be reviewed at the monthly QA meeting.	**3/7/12**

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F 323	Continued From page 21 On 2/9/12, E15 (Unit Clerk) confirmed the findings and stated that she would call maintenance.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to ensure that two (R65 and R73) out of 51 Stage 2 sampled residents received proper respiratory care in regards to oxygen concentrator units not being properly maintained. Findings include: 1. On 2/6/12 at 10:55 AM during the environmental tour, a filter on the oxygen concentrator for R73 was observed heavily coated with dust and lint. On 2/6/12, in an interview with E17 (LPN), she stated that she was unaware who cleaned the filters.	**F 328**	1. Concentrator filters on identified residents were cleaned. 2. All filters of concentrators in use were cleaned. 3. A. "Oxygen Concentrator" policy was revised to include weekly cleaning of filters on the 11-7 shift (see attached) B. Nursing staff in-serviced on new policy (see attached) C. The 11-7 cleaning schedule was modified to include cleaning of concentrator filters every Wednesday. (see attached form) D. Cleaning of oxygen filters has been added to the TAR (Treatment Administration Records) for residents using concentrators E. The supervisor report which is completed each shift has been revised to include checking concentrator filters and weekly cleaning. (see attached form) F. DON or designee will review the supervisor reports and respond to any concerns related to concentrator filters. 4. Findings of reports will be reviewed at the monthly QA meeting.	**3/7/12**

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F 328	Continued From page 22 The facility failed to have a clean filter on the oxygen concentrator for R73. On 2/6/12, in an interview with E16, (RN Staff development), she confirmed the finding. 2. On 2/8/12 at 9:55 AM, a filter on the oxygen concentrator for R65 was observed heavily coated with dust and lint. On 2/8/12, in an interview with E16, she confirmed this finding.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. Unable to make corrections on this past practice. 2. Medical records for all residents receiving psychotropic medications were reviewed to insure documentation of appropriate behavior monitoring log reflects current or targeted behaviors/symptoms 3. A. Staff were in-serviced on proper completion of the behavior monitoring log. (see attached) B. Psychoactive tracking tool has been revised to include behaviors/symptoms. This tool as well as the behavior monitoring forms will be reviewed at the monthly psychotropic reduction meeting according to the resident's schedule and as needed. (see attached form) 4. Tracking tool findings will be reviewed at the monthly QA meeting.	3/7/12

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F 329	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to ensure that one (R6) out of 51 Stage 2 sampled residents receiving sedative-hypnotic and antipsychotic medications had adequate monitoring/documentation indicating the behaviors or symptoms requiring the use of these medications in the clinical record. Findings include: Review of R6's medical record revealed that the Psychotropic Reduction Meeting on 11/29/11 noted that R6's diagnosis included depression/anxiety. Review of facility policy undated and entitled, "Psychotropic Medications" stated, "It is the policy of this facility that psychotropic medication therapy be used only when necessary to treat a specific condition. Procedure # 3 stated, "Adverse reactions or potential reactions to the psychotropic medications will be documented on the Behavior Monitoring Form." Review of R6's care plan, dated 7/19/10, for psychotropic drug use for antidepressant, antipsychotic and anti-anxiety medications included the following approaches: medication as ordered, monitor for signs and symptoms of adverse drug reactions (ADR) and effectiveness of medications, medication review at least every 90 days and psych consult as needed. Review of nurses notes for 3/9/11 thru 2/3/12,	F 329		

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F 329	Continued From page 24 revealed that there was no documentation that R6 was being monitored for behaviors and ADR's for the use of antipsychotic/anti-anxiety medications. Interviews on 2/3/11 with E4 (nurse) and E5 (nurse), confirmed that nursing was to be documenting the resident's behavior and any ADR's for residents that are taking anti-anxiety and antipsychotic medications every shift on the behavior flow sheets. Additionally, E5 stated, "If something extreme happens then we will write a nurse's note and notify the doctor". Review of R6's Medication Administration Record (MAR) for December 2011 and January 2012 revealed that the resident had monitoring flow sheets for the following behaviors: tearful, anxious and panic. The medications that were given for these behaviors were Clonazepam and Alprazolam. The day and evening shifts failed to consistently monitor R6 for behavior and ADR's on the behavior monitoring sheets. Findings were discussed with E2 (Director of Nursing) on 2/3/12.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that it	F 332		

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F 332	Continued From page 25 was free of medication error rates of five percent or greater. During the Medication Pass observations on 2/6/12, it was observed that the administration of drugs were not in accordance with the manufacturer's recommendations. The Medication Error rate was 5.88% involving 2 (R20 and R33) out of 12 residents with 51 opportunities. Findings include: There were 3 medication errors with 51 opportunities resulting in a 5.88% medication error. Errors included: 1. Review of R20's February 2012 monthly physician order sheet revealed medication orders that included, "Dorzolomide HCL Instill 1 drop into both eyes twice a day for glaucoma and Pilocarpine 1% eye drops. Instill 1 drop into the left eye daily for glaucoma." On 2/6/12 at 08:55 AM, E12 (nurse) was observed during a medication observation pass preparing medications to administer to R20. E12 stated that she was going to administer the Trusopt (Brand name of Dorzolomide HCL) and then wait five (5) minutes before administering the Pilocarpine eye drops. When questioned if she had ever looked up those medications, E12 stated that she would give the Pilocarpine first... wait 5 minutes, then administer the Trusopt, still unsure of herself. The surveyor asked if she had a drug book since there was none on the med cart. E12 went to the nursing desk where there were four drug books and proceeded to look up the medications. Review of the "Nursing 2012 Drug Handbook" stated, "dorzolamide hydrochloride	F 332	1. Unable to make corrections on this past practice. 2. A. All residents with multiple eye medications were reviewed to ensure proper time interval between medications. B. Medication Pass competencies were completed by nursing administration. (see attached form) 3. A. "Medication Administration" and "Administering Eye Drops" Policies were revised (see attached) B. Nurses were in-serviced on these polices (see attached) C. Three Kutz Home nurses attended the Division of Long Term Care/Quality Insights sponsored Medication Summit on 2/23/12 and will attend the follow up meeting on March 3/13/12. D. As recommended at the Medication Summit, a medication administration video series was purchased on 2/29/12 and received on 3/6/12. This series will be utilized to review proper medication administration. (see attached information) All nurses will be required to review this training initially and then annually thereafter. E. Medication competencies will be completed annually (see attached) 4. Competency results will be reviewed at the monthly QA meeting.	3/7/12

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F 332	Continued From page 26 (Trusopt)....Administration ophthalmic...If more than one ophthalmic drug is being used, give at least 10 minutes apart." E12 stated, "Oh, 10 minutes..." E12 stated that she did not know that Trusopt required 10 minutes before administering another eye medication. E12 confirmed that she would have given it and only waited 5 minutes had the surveyor not stopped her and had her look it up. E12 stated that she had given eye drops before but had never given Trusopt. She agreed with the surveyor that it is always a good practice to look up any unfamiliar drug in the drug book. During the informational meeting on 2/10/12, findings were discussed and acknowledged by E1 (Administrator) and E2 (Director of Nursing). E1 stated that E12 had been removed from the schedule and would not be returning to the facility. 2A. Review of the facility's policy and procedure on "Administering Eye Drops" revealed, "Hold the dropper tip directly over the eye, taking care to avoid touching the eye or eyelid." Review of R33's February 2012 monthly physician order sheet revealed medication orders that included, "Brimonidine Tartrate 0.15% (Alphagan) instill 1 drop into both eyes every day for Glaucoma and Azopt 1% instill 1 drop into both eyes twice daily for Glaucoma." On 2/6/12, during the medication pass observation, E9 (nurse) incorrectly administered Alphagan eye drops to R33 when E9 touched the tip of the bottle of Alphagan eye drops to R33's	F 332		

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F 332	Continued From page 27 eyes during administration. R33, an alert and oriented resident, confirmed that the bottle of eye drops touched both of her eyes during the administration. 2B. Review of The Geriatric Dosage Handbook, 16th edition, that was located at the nurses' station between the 100 and 200 units, stated the following for Brinzolamide (AZOPT), "...If more than one topical ophthalmic drug is being used, administer drugs at least 10 minutes apart." E9 stated that it was his practice to administer the Alphagan and Azopt eye drops 5 minutes apart. During the Medication Pass observation on 2/6/12, the surveyor stopped E9 from administering the Azopt eye drops 5 minutes after the Alphagan eye drops. E9 stated that he was not aware that he had to wait at least 10 minutes to administer Azopt after the administration of Alphagan eye drops. Also, E9 stated that he had administered the same eye drops 5 minutes apart on February 1, 2, 3, 2012 upon review of the 2/12 Medication Administration record (MAR) with him. On 2/6/12, in an interview with R33, an alert and oriented resident, she stated that she has had no recent changes in her eyes. She stated that she has been on the eye drops for years and they work. She had no complaints about pain or visual issues. On 2/6/12, in an interview with E11(nurse/unit manager) was advised of the Medication Pass observation. She stated that she would obtain	F 332		

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F 332	Continued From page 28 physician orders for R33's eye drops with a time interval of 10 minutes between the eye drops and put it on R33's MAR. Additionally, E11 stated that she would throw out the contaminated Alphagan bottle and obtain a new bottle for R33.	F 332		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	**F 441**	1. Unable to make corrections on this past practice. 2. A. "Administration of Eye Drops" and "Medication Administration" policies were revised. (see attached) B. In-services for eye drop administration and wound care were held for nurses, and hand washing in-service for all nursing staff. (see attached) C. Competencies for all nurses were completed on the following (see attached forms): • Wound Care (nurses) • Medication administration (nurses) • Hand washing (all nursing staff) 3. Wound care, medication administration and hand washing competencies will be completed annually by the Staff Educator or Designee. 4. Results of the competencies will be reviewed at the monthly QA meeting.	**3/7/12**

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F 441	Continued From page 29 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to maintain infection control practices designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of disease and infection in regards to dressing changes and disposal of soiled dressings, proper administration of eye drops, and proper hand washing techniques for five (R44, R22, R33, R89, R45) out of 51 Stage 2 sampled residents. Findings include: 1. Observation on 2/3/12 at 11:00 AM of R44's wound and dressing change with E6 (nurse) revealed that E6 did not take off her gloves and wash her hands after she cleaned R44's sacral wound with gauze and normal saline and had been touching the inside of the wound with her gloved hands. In addition, when E6 came into R44's room to perform the dressing change, she proceeded to throw her keys on the resident's bed which stayed there through out the dressing change. Findings were discussed with E6 and the Director of Nursing on 2/3/12. 2. On 2/6/12 6:27 AM, E18 (LPN) was observed changing a dressing on R22's pressure ulcer.	F 441		

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F 441	Continued From page 30 Upon completion of the dressing change, E18 took the "dirty" biohazard bag which contained the soiled dressing and used supplies and placed it on top of the "clean" treatment cart next to clean disposable pads located outside of the resident's room. E18 went back inside R22's room, removed her gloves and washed her hands. Then, E18 pushed the treatment cart down the hall to the nurses' station with the biohazard bag on it. She took the bag into the locked soiled utility room and disposed of it into a large red biohazard bag and washed her hands. On 2/6/12 at 6:50 AM in an interview with E18, she confirmed that she placed and left the biohazard bag with the soiled dressings on the treatment cart next to the disposable pads to wash her hands. Further, she confirmed that she rolled the treatment cart with the biohazard bag on it back to the nurses' station prior to disposing the biohazard bag into the soiled utility room. The facility failed to maintain infection control practices regarding disposal of biohazard waste. On 2/6/12 at 7AM, during the interview, E16 stated that the biohazard bag should have been taken directly to the soiled utility room. Further, E16 stated that she would have the treatment cart disinfected and would have the potentially contaminated pads that were on top of the treatment cart thrown out. 3. On 2/6/12, during the Medication Pass Observation, contamination occurred when the tip of the bottle containing Alphagan eye drops touched R33's eyes during the administration by E9 (nurse). The resident confirmed that her eyes were touched with bottle of eye drops.	F 441		

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F 441	Continued From page 31 The facility failed to maintain infection control practices related to eye drop administration. On 2/6/12, E11 (nurse/unit manager) who was advised of the above, stated that she would obtain a new bottle of Alphagan and throw out the one that was contaminated when it touched R33's eyes. On 2/7/12, E2 (DON) stated that she would have nurses in-serviced on administration of eye drops. The facility policy and procedure, dated Rev (revised): 2/2010 and entitled, "Handwashing" was reviewed. 4. During the medication pass observation on 2/6/12 at 7:55 AM, before administering medications to R89, E6 (nurse) washed her hands at the sink in the 300-400 unit supply room. After washing her hands, E6 dried her hands and used the same wet paper towels to turn off the faucet and wipe the sink which could potentially spread germs. This observation was discussed and confirmed by E6. E6 then proceeded to wash her hands again, using proper hand washing/infection control techniques. During the informational meeting on 2/10/12, findings were discussed and acknowledged by E1 (Administrator) and E2 (Director of Nursing). 5. On 2/6/12 at 8:25 AM, after administering insulin to R45, E12 (nurse) was observed entering R45's bathroom. E12 rinsed her hands less than 10 seconds and dried them using paper towels and was proceeding to do the next resident's medication pass. When asked if she had washed her hands, E12 stated, "Yes"... then was asked if she needed to use soap in order to	F 441		

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F 441	Continued From page 32 wash hands properly... E12 acknowledged that she had not used soap. E12 re washed her hands, turned off the faucet using her bare right hand and then dried her hands with clean paper towels and discarded them in the trash. The surveyor informed E12 that she needed to re wash her hands. When asked if she knew what she did, E12 stated that she had failed to use a paper towel to turn off the faucet. E12 then proceeded to wash her hands again, using proper hand washing/infection control techniques. During the informational meeting on 2/10/12, findings were discussed and acknowledged by E1 (Administrator) and E2 (Director of Nursing). E1 stated that E12 had been removed from the schedule and would not be returning to the facility.	F 441		
F 501 SS=D	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the medical care for one (R109) out of 51 Stage 2 sampled residents was coordinated by the medical director in relation to dialysis services. Additionally, there were policies that the facility revised pertaining to dialysis and administration of	F 501		

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F 501	Continued From page 33 eye drops and then provided to the surveyors as the current policy despite the Medical Director not having reviewed/approved them. Findings include: Cross Refer F309 The facility failed to coordinate medical care between the dialysis center and the facility for R109. On 2/10/12, in an interview with E24 (Medical Director), he stated that when a resident was on dialysis he would expect that there would be monitoring that the resident was going to dialysis per the schedule, pre and post weights provided, notes from dialysis including lab results and that there would be a communication to and from dialysis. E24 further stated that he would expect the facility staff to monitor intake/output, change in condition, graft site and communicate with dialysis. He stated that weights needed to be sent to dialysis from the facility because, "that helps with what the dialysis bath will be... vital signs should be sent". When asked if he had the occasion to communicate with dialysis for R109, E24 responded, "I have not talked directly with dialysis". E24 stated that he would review the communication from dialysis if the resident was his patient and if it was not his patient, then the facility would call if there was a concern and then as Medical Director, he would review it. He stated, "alot of time we'll send a written message/communication to the dialysis unit and then come back with a message/ communication from dialysis". Additionally, E24 stated that if there was verbal communication, then nursing would document the call and call if a verbal order	F 501	1. An inter-facility Dialysis Communication form documenting resident status pre and post dialysis was initiated and implemented on 2/10/12. (see attached form) Attending physician is required to review communication forms and modify treatment plan as indicated 2. The attending physician will reviewed the Weekly Dialysis Audit tool for resident #R109 and any future residents receiving dialysis to insure proper coordination of care (see attached) 3. A. The "Care of a Dialysis Resident" policy was revised to include physician review of the Dialysis Communication log on a regular basis. (see attached) B. All Attending physicians received the revised policy as well as the Dialysis Communication log. (see attached letter) C. All new /revised policies will have a sign off date when reviewed by the QA meeting of which the Medical Director is a member. The Medical Director and QA chairperson will sign off on all revised policies reviewed at the monthly QA meetings. D. Residents receiving dialysis will be reviewed during the weekly SWIFT meeting, and the Weekly Dialysis Audit tool will be completed for physician review (see attached)	

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F 501	Continued From page 34 was needed. E24 reviewed E109's record and there was only one lab, dated 1/20/12(abnormal results), and one dietician recommendation, dated 1/26/12, that noted, "dialysis report ^ (increased) wt (weight) gain". E24 stated, "I have not seen any communication from dialysis for me to review". E24 confirmed that the lab results dated 1/20/12, were the only lab results that he had reviewed for R109 from 1/18/12 through 2/5/12 when he sent the resident out to the hospital for complaints of shortness of breath. E24 reviewed the "Care of the Dialysis Resident" Policy and Procedure revised 1/2012. He stated, "He was not sure if it was the official one since we may be still modifying...There could be more on it. Bruit and thrill in past few meetings (QAA) were discussed. I suggested the bruit and thrill be added...would have signed and approved the 1/12 policy." E24 stated that he expected that the facility would check a dialysis resident for bruit and thrill, expect alot more communication between dialysis and the facility, and expect better documentation by the nurses. E24 stated, "I would expect them to do their job without me doing it for them". E24 reviewed a "Care of the Dialysis Resident" policy and procedure with a revision date of 2/2012 and E24 stated that he had not signed off on this policy. He stated that he, "Felt that communication with and from dialysis was very important and should have been included on the previous policy...This is the first time I saw this...Had not seen the communication form...I	F 501	4 Dialysis communication logs will be audited to ensure that physician review has taken place. Results will Policies reviewed at monthly QA meeting.	3/7/12

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F 501	Continued From page 35 don't have an answer as to why the communication form or any communication between dialysis and the facility was not done. There have been no sign offs on the policy since 9/12/11...I had no input on the communication form but felt that it was a great idea." E24 was advised by the surveyor that E3 (ADON) gave the surveyor the, "Care of the Dialysis Resident" policy and procedure revised 2/2012 upon entrance to the facility on 2/10/12. E3 stated that the policy was revised last night after speaking with the dialysis unit. It also included the "Kutz Home/Dialysis Communication Form". E24 also reviewed the "Administering Eye Drops" policy and procedure revised 2/2012. E24 stated that he had not seen this policy. He stated that there were always ongoing changes. He also stated that he would expect nurses to know updates for medications. Again, E24 was informed by the surveyors that the facility had provided the revised policy and a sign in sheet that facility nurses were inserviced on 2/7/12 to the Eye Drop Administration policy and procedure revised 2/2012. The facility failed to ensure the medical care was coordinated for R109 in relation to dialysis services by the Medical Director. Additionally, the facility provided two (2) policies and procedures to the surveyors that had been revised during the survey but had not been reviewed/approved by the Medical Director.	F 501		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON & HATTIE KUTZ HOME	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 36 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain clinical records that were complete and accurately documented for two (R92 and R109) out of fifty-one (51) Stage 2 sampled residents. Findings include: 1. Review of R92's 1/12 Medication Administration Record (MAR) lacked documented evidence that eight (8) medications timed for 8 PM were administered on 1/6/12. During an interview on 2/8/12 at 2:30 PM, E9 (nurse) stated that he remembered administering these medications but believed he was "called away" and forgot to document them. During an interview on 2/8/12 at 2:35 PM, E10 (nurse/Unit Manager) acknowledged the findings and stated that she has always been taught that "if it's not signed... it wasn't given." Review of the facility's policy and Procedure for	F 514	1. Unable to make corrections on this past practice. 2. A. The "Physician Orders" policy was revised (see attached) B.A new four part Doctor's order form has been implemented. (see attached form) C. The policy now calls for the 11-7 nurse to receive a copy of the physicians' order form to ensure that all new orders are transcribed accurately on to the new months' POS (Physician Order Sheets, MAR (Medication Administration Record) and TAR (Treatment Administration Record) D. The monthly recaps will arrive at the facility on 26th instead of the 20th to decrease the number of orders to transcribe onto the new month's forms. 3. A. During the last 11-7 shift of each month, the Night Shift Supervisor or a Designee will check each chart to insure all new orders written since the 26th of the month are on the new month's POS, MAR and TAR B. Chart audits will be completed on a quarterly basis to ensure accuracy with monthly medication transcription. C. Transcription errors are treated as Medication errors and will be tracked by the DON or a Designee D. Night Shift nurses have been in-serviced on the revised process (see attached) 4. Chart audit and Medication errors will be reviewed at the monthly QA meeting.	3/7/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 02/10/2012

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F 514	Continued From page 37 "Administering Medications", dated Rev (revised) 07/2010 stated, "... 6. The nurse must then initial the resident's MAR in the appropriate line and date for that specific day before administering the next resident's medication..." Review of the facility's incident report, dated 2/9/12, listed the corrective action taken was "Nurse spoken to and made aware... that he needs to start signing medications off right after the resident takes medication..." The facility failed to maintain clinical records that were complete and accurately documented for R92. Cross refer F309 2. Review of R109's Physician's order, dated 1/26/12 stated, "...Wghts (weights), 3 X (times) weekly..." Review of the 1/12 MAR only revealed a physician's order, dated 1/18/12 that stated, "Weekly weights X 4" and timed to be done on the 7-3 shift. The only weights documented on the 1/12 MAR were on 1/23/12 and 1/30/12. The facility failed to transcribe the most recent order. Review of R109's Physician's order, dated 2/3/12 stated, "Clarification order: Resident to be weighed 3 X a wk (week) on Mon., Wed., Fri." Review of R109's 2/12 MAR lacked evidence that any weights were done before 2/3/12, when the clarification order was obtained and then transcribed onto the 2/12 MAR. During an interview on 2/10/12, E11 (nurse) confirmed the findings. E11 stated that the facility failed to transcribe the order, dated 1/26/12, for doing weights three times a week on the 1/12 MAR, which "resulted in it (the order) not being carried over" to the 2/12 MAR. E11 stated that is	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 38 "why the weight was missed on 2/1/12." The facility failed to maintain clinical records that were complete and accurately documented for R109.	F 514		

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Milton & Hattie Kutz Home

DATE SURVEY COMPLETED: February 10, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State report incorporates by reference and also cites the findings specified in the Federal report. An unannounced annual and complaint survey was conducted at this facility from January 30, 2012 through February 10, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 84. The Stage II survey sample totaled fifty-one (51) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby**	**Cross refer to:** **F 164, F 246, F 253, F 278, F 280, F 309, F 323, F 328, F329, F 332, F 441, F 501, and F 514** **Date of Completion – 3/7/12**

Provider's Signature _____ Title Executive Director Date 3-7-12

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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3 Mill Road, Suite 308
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NAME OF FACILITY: Milton & Hattie Kutz Home

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey date completed 2/10/12, F164, F246, F253, F278, F280, F309, F323, F328, F329, F332, F441, F501, and F514.	